Strategic Goal 3
Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation

Secretary Priority: *Provide high-quality health care that meets or exceeds community standards.*
Secretary Priority: *Provide access to primary care appointments and specialty care appointments within 30 days, and ensure patients are seen within 20 minutes of their scheduled appointment.*
Secretary Priority: *Ensure access to high-quality health care for veterans with service-connected conditions and veterans who are poor.*
Secretary Priority: *Maintain the high level of service to insurance policy holders and their beneficiaries.*
Secretary Priority: *Ensure the burial needs of veterans and their eligible family members are met.*
Secretary Priority: *Ensure graves in national cemeteries are marked in a timely manner.*

Veterans will have dignity in their lives, especially in time of need, through the provision of health care, pension programs, and life insurance; and the Nation will memorialize them in death for the sacrifices they have made for their country. To achieve this goal, VA needs to improve the overall health of enrolled veterans, provide a continuum of health care (which includes special populations of veterans), extend pension and life insurance benefits to veterans, meet the burial needs of veterans and eligible family members, and provide veterans and their families with timely and accurate symbolic expressions of remembrance.

Several key performance measures enable us to gauge progress toward achieving this strategic goal:

- Chronic Disease Care Index II
- Prevention Index II
- Patient Safety - bar code medication administration
- Patient satisfaction with health care service
- Waiting times for appointments and treatments
- Cost and efficiency for the health care system
- Average days to process insurance disbursements
- Percent of veterans served by a burial option
- Quality of service provided by national cemeteries
- Timeliness of marking graves in national cemeteries

Provide High Quality Health Care

Strategic Goal: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

Secretary Priority: Provide high-quality health care that meets or exceeds community standards.

Performance Goals

1. Improve performance on the Chronic Disease Care Index II to 79 percent.
2. Maintain performance on the Prevention Index II at 80 percent.
3. Ensure all facilities have a contingency plan for the loss of the electronic ability of the Bar Code Medication Administration (BCMA) process.
4. Increase to 68 and 69 percent, respectively, the proportion of inpatients and outpatients rating VA health care service as "very good" or "excellent."
5. Decrease the percent of Veterans Service Standard problems reported per patient in the areas of patient education and visit coordination.
6. Increase the Balanced Scorecard: Quality-Access-Satisfaction-Cost to 102 percent.

Current Situation Discussion

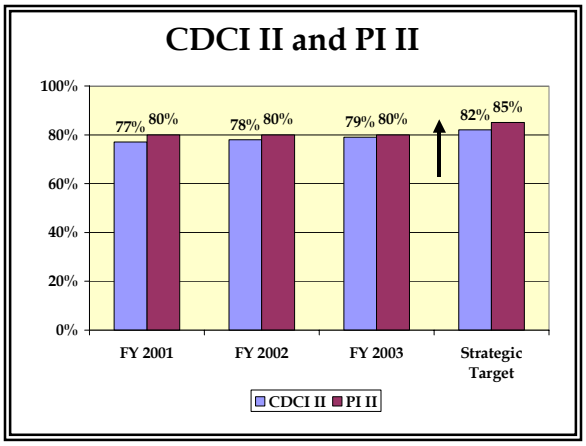
VHA's strategy to achieve these goals addresses VA's priority of high quality medical care, access to that care, and timeliness of health care services. VHA assures that its policies are carried out through a strategic management framework that relies on performance goals and a performance measurement program that monitors progress and promotes accountability. The management framework is comprised of the Domains of Quality: quality, patient satisfaction, functional status, access, cost efficiency and building healthy communities.

VA provides a continuum of patient-centered health care that includes health care for special populations of veterans. While providing care to veterans who use the system, VHA also works to ensure that the health care system meets the special needs of disabled and lower-income veterans. It is a fundamental policy of VA that those veterans who come to us for their health needs will receive the highest quality of health care available.

Chronic Disease Care Index II (CDCI II) and Prevention Index II (PI II)

The CDCI II is one of two primary quality of care measures used by VA. Investment in effective chronic disease management results in improved health outcomes for veterans. The multiple CDCI II is comprised of the evidence and outcomes-based measures for high-prevalence and high-risk diseases that have significant impact on overall health status.

VHA's PI II, the second major quality of care composite measure, spotlights and summarizes VHA's performance on a variety of evidence-based measures for high quality preventive health care.

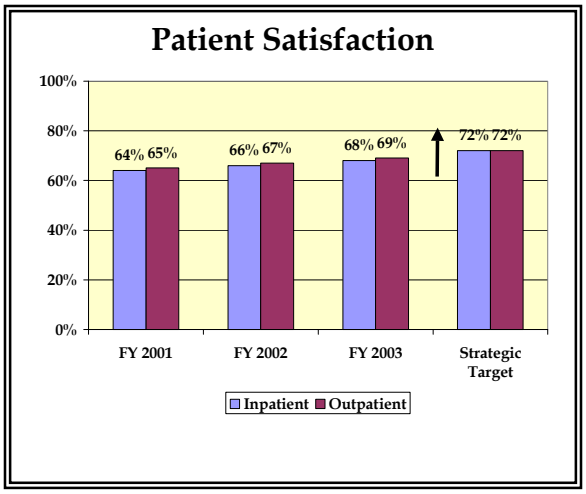


The chronic disease care and prevention indices were recently redefined and updated after several years of increasingly higher performance. The changes add new challenges in the areas of health promotion and disease prevention – areas in which VA is considered an industry leader when compared to the private sector.

Patient Safety

VHA has adopted patient safety procedures in VA facilities. In FY 2002, VA will evaluate a major patient safety process. VHA's National Center for Patient Safety (NCPS) will collect contingency plans from each VHA facility for coping with loss of the electronic medication administration procedure called Bar Code Medication Administration (BCMA) system. The contingency plans will be based on the Healthcare Failure Modes and Effects Analysis (HFMEA), and NCPS will assess the adequacy of each plan to provide viable workarounds to potential BCMA system failures. Plans are due to the NCPS by 8/31/02. Data will be reported by NCPS to the Office of Quality and Performance by 9/31/02 for inclusion in FY 2002 performance results. Establishing a contingency plan at each facility will also meet the new JCAHO requirement for "proactive risk assessment" of a process critical to patient safety.

It is expected that VHA will meet target for this measure in FY 2002 due to the critical need for contingency plans for BMCA. It is expected that another measure will be established based on trend analysis of data from root cause analyses generated at the medical centers.

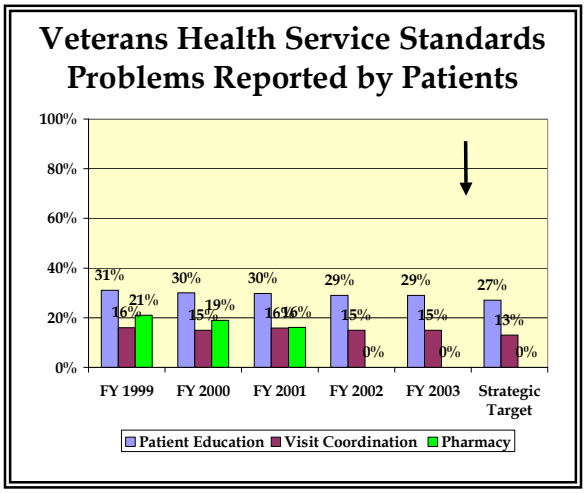


VHA's National Center for Patient Safety (NCPS), winner of the 2001 Innovations in American Government Award, was created to take the lead in integrating patient safety efforts and innovations, and to develop and nurture a culture of

safety throughout VHA. NCPS's primary goal is nationwide reduction and prevention of harm caused by adverse events. In 2001, in addition to providing training in support of the new patient safety orientation video and training module for all new VHA employees.

Patient Satisfaction

VA relies heavily on periodic feedback from veterans, obtained through surveys, as to the level of their satisfaction with service. VA's Performance Analysis Center for Excellence (PACE) conducts national satisfaction surveys that allow VHA to better understand and meet patient expectations. The surveys target the dimensions of care that concern veterans the most. Surveys are sent to patients who have received care in a variety of settings, for example, inpatient, outpatient, home-based, and certain special emphasis programs. Veteran satisfaction performance is externally benchmarked to other large organizations. Due to a new survey process, the FY 2002 measures for patient education and visit coordination are changed. The pharmacy measure was dropped because the goals related to it were satisfactorily accomplished.



Balanced Scorecard

The VHA Balanced Scorecard utilizes four of the same components found in the Quality-Access-Satisfaction (QAS)/Cost Value Index but establishes a percentage goal for cost in the same manner as done for desired outcomes for QAS. These four components of the scorecard are weighted equally to achieve a balanced scorecard value. Each component has a weight of twenty-five percent. The total balanced scorecard value is the sum of the percent goal achievement for each of the components. The balanced

scorecard provides a framework for translating VHA's strategic objectives into performance measurements driven by the key performance measures of quality, access, and satisfaction.

Means and Strategies

Chronic Disease Care Index II

VA ensures the consistent delivery of health care by implementing standard measures for the provision of evidence-based care by focusing on the use of a Chronic Disease Care Index (CDCI). This index is based on the performance of specific processes, provision of certain clinical services, or achievement of certain (proxy) outcomes for which the medical literature has documented evidence of a relationship to good health outcomes.

The CDCI II measures how well VA follows nationally recognized clinical guidelines for the treatment and care of patients with one or more of the following high-volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, congestive heart failure, major depressive disorder, schizophrenia and tobacco use cessation. A large percentage of veterans have one or more chronic diseases and the improved management of chronic diseases results in improved health outcomes for veterans. The CDCI II has replaced the CDCI. The new measure consists of 23 separate clinical interventions associated with the eight cohorts discussed above, while the previous measure used 13 clinical interventions. The performance target for the CDCI II is estimated from a composite of performance on the 23 separate indicators.

Prevention Index II

The majority of diseases that cause disability or death among Americans could be prevented or delayed through screening, education, and counseling aimed at risk-factor identification and behavior modification. Through its education programs and screening tests, VA urges veterans to become aware of ways in which health can be enhanced, and encourages each person to assume individual responsibility to achieve this goal. The goals of preventive medicine are to maintain health and achieve early detection of disease, thereby easing the burdens associated with cost, suffering, and resource availability in chronic disease management.

VA has designed a prevention index that includes several indicators that allow a comparison of VA and private sector health care outcomes. Again, the original Prevention Index has been replaced by the Prevention Index II (PI II). The PI II has added an additional screening indicator for high cholesterol and removed tobacco counseling.

This index charts the outcomes of nine medical interventions that measure how well VA follows national primary-prevention and early-detection

recommendations for several diseases or health factors that significantly determine health outcomes: immunizations for both pneumococcal pneumonia and influenza; screening for tobacco and problem alcohol use; cancer screening for colorectal, breast and cervical cancer; screening for hyperlipidemia; and counseling regarding the risks and benefits of prostate cancer screening. VA provides preventive interventions, which are important for a population of healthy as well as severely ill and disabled veterans. Data contained in the PI II are based on statistically developed random samples that support valid extrapolations of the percentages of patients receiving appropriate medical intervention, whether in the form of immunizations, screening, or counseling. These measures were initially reported for only primary care clinics. Over time, both the implementation and reporting of such measures have been expanded to include related specialty clinics. Through the PI II, VA continues to demonstrate progress in improving systems that support preventive care delivery. For example, the automated medical record system and a system of clinical prompts and reminders facilitate care delivery at the point of patient contact, ensuring that veterans receive appropriate interventions. To effectively implement the PI II, Networks will continue to utilize a variety of strategies including the following:

- implementation of new clinical guidelines and refinement of existing guidelines
- implementation of patient and staff education programs on the importance and benefits of prevention
- continuation of monthly monitoring of local performance using checklists to ensure that preventative activities are accomplished as scheduled for the patients receiving the desired intervention charging primary care teams with responsibility and accountability for local implementation of the PI II.

Patient Safety

VA is committed to continuously improving the culture of patient safety in its health care facilities. An important aspect of this is to develop a good understanding of the causes of safety problems. VA uses root cause analysis (RCA) to accomplish this. RCA is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or "close calls" involving VA patients.

The successful meeting of the RCA performance goals for FY 2001 ensured that VA identifies the root cause of variance in performance in a timely manner.

The future goal in patient safety is to assure that a contingency plan is in place and tested in the event of loss of the electronic ability to use the BCMA system. The plans will be submitted to the NCPS for review.

Patient Satisfaction

VA obtains continual feedback from the veteran user population on their satisfaction with service through surveys, focus groups, complaint handling, direct inquiry, and comment cards. This feedback is used to build a database on what customers expect and provides information that can be used to revise performance goals and identify areas for improvement. Surveys are sent to patients who have received care in a variety of settings.

Networks will continue to implement strategies geared to improving patient satisfaction by access by creating and maintaining community-based outpatient clinics (CBOC), opening weekend clinics, employing case managers, building permanent clinic screening teams, and making infrastructure improvements, such as a VISN-wide Guest Services Program. VA seeks input from veterans service organizations to improve access, quality of care, and veteran satisfaction.

These performance goals are intended to measure patient satisfaction with health care services in select areas. The performance data are derived from a number of questions on the Performance Analysis Center for Excellence (PACE) inpatient and ambulatory care satisfaction surveys that will be part of VHA's overall Survey of Health Expectations of Patients (SHEP).

VHA's success in promoting patient satisfaction was recently recognized by the rankings of the 2001 American Customer Satisfaction Index (ACSI). The ACSI is produced through a partnership among the University of Michigan Business School, the American Society for Quality, and the Claes Fornell International (CFI) Group. The index contains numerical rankings of companies, agencies, and economic sectors on a 100-point scale, based on more than 50,000 interviews annually. The 2001 results show that VHA achieved satisfaction rankings that far exceeded private sector hospitals and other government service ratings. VA hospitals achieved a satisfaction rating of 82 for inpatient care. This compares favorably to the rating of 71 for the private sector and the 68 for the Federal Government. VA outpatient pharmacy services achieved a satisfaction rating of 83 percent, which was a full 12 points higher than the comparable private sector retail rating of 71. VA's outpatient satisfaction rating of 79 far exceeded that of all organizations (70.5) and the Federal Government-wide score (68.6)

Balanced Scorecard

The specific means and strategies that will be employed to meet this performance goal are the same as those identified for the specific components comprising these new measures — Chronic Disease Care Index II; Prevention Index II; inpatient and outpatient satisfaction; and waiting times for primary care, specialty care clinics.

Crosscutting Activities

CDCI II and PI II

VHA continues its association with the Agency for Health Care Research and Quality in monitoring and refining CDCI (II) and the PI (II). VA also works with DoD regarding prevention, although the actual areas measured may be different, indicators and identification of at-risk populations are routinely coordinated with the DoD via a process similar to the clinical practice guidelines process.

Patient Safety

VHA continues its association with the DoD in developing and refining the measures that comprise the CDCI and PI II. Although actual areas measured may be different, indicators and identification of at-risk populations are routinely coordinated by the use of co-authored clinical practice guidelines.

Balanced Scorecard

While VA does not rely exclusively on any other organization for support of the performance goals in the balanced scorecard, there are nevertheless a number of crosscutting activities that impact upon our ability to function in a cost-effective manner. For instance, VA collaborates with HHS to develop non-VA benchmarks for bed days of care, which are obtained from a Centers for Medicare and Medicaid Systems database. In addition, VA is able to obtain data on ambulatory procedures from the National Center for Health Statistics. VA also collaborates with the DoD on Joint Contracting for Pharmaceuticals, enhancing VA's Parametric Automated Cost Engineering System, partnering on real property assets, and acquisition and collocation of VA facilities with excess property available through the closure of military bases. VA also participates in joint design and construction projects with the Department of Agriculture, Indian Health Service, Public Health Service, National Park Service, and Merchant Marine Academy.

Other crosscutting activities that impact the balanced scorecard include providing laundry services to state veterans homes and Job Corps programs, collaborating with the General Services Administration in a Government-wide Real Property Information Sharing program on utilization of Government-owned and Government-controlled real property in the Northeastern area of the United States, and acquiring leasehold interests in real property for clinical and administrative purposes within various regions across the country. Also, VA participates with a private sector panel to identify enhanced-use lease initiatives at various VA medical centers for the purpose of obtaining lower cost utilities and energy services, thus making more resources available for direct patient care.

External Factors

There are no external factors impacting on these performance measures.

Major Management Challenges

Patient Safety

VA's Office of Inspector General (OIG) has identified patient safety as one of VA's ten most serious management challenges. OIG's report to Congress dated November 20, 2000, emphasized that VA needs to ensure high quality of veterans' health care and patient safety, and to demonstrate that health care programs are effective. Factors contributing to the problem are the rapid pace of ambulatory care, which increases the likelihood that clinicians will make errors in treating patients, and the absence of a system to accurately identify and correct treatment errors.

VA has responded to all of the OIG's recommendations to improve patient safety and quality management activities. VA's establishment of the National NCPS and national training on the principles of root cause analysis represent an aggressive response to recommendations made by the OIG. The focus that the NCPS has placed on the issue of patient safety and on resolving long-time patient vulnerabilities will go a long way toward making sure that VA patients receive proper care in a safer environment.

Data Source and Validation

Chronic Disease Care Index II (CDCI II) and Prevention Index II (PI II)

Data for the CDCI and PI are collected through medical chart reviews. The sampling methodology relies upon "established" patients who have been seen at least once in one of eight primary care or specialty clinics. The External Peer Review Program (EPRP), a contracted, on-site review of clinical records, is the data source for both Indices. The EPRP contractor evaluates the validity and reliability of abstracted data using accepted statistical methods. Ongoing inter-rater reliability assessments are performed quarterly for each abstractor in the review process. A random sampling protocol is used to select individual patient charts. Abstractors then review the charts to determine if appropriate data are included. The resulting data are aggregated into appropriate indices. A report is produced quarterly that is available to each VISN.

The EPRP serves as a functional component of VHA's quality management program by:

- providing information for use as a part of VHA's continuous quality improvement program
- identifying opportunities for improvement in care

- establishing a database for the analysis and comparison of patterns of care at all levels

The numerator for individual indicators is typically based on the number of patients who received the specified intervention, clinical service, or have achieved (proxy) outcome. The denominator for the calculation is the number of patients who are eligible for the intervention or who have the disease. Data are abstracted on-site monthly.

Patient Safety

The 45-day timeliness measure for root cause analysis (RCA) was developed for use as a companion compliance measure for the national rollout in FY 2001. This measure will not be formally reported beyond FY 2001, and, thus, it appears for the final time in this iteration of the VA Performance Plan. The source for root cause analysis data is the Patient Safety Information System established by the NCPS. The numerator for this measure was the number of root cause analyses conducted within 45 calendar days, or within the allocated extension time. The denominator was all RCAs in the Patient Safety Information System. Future iterations of the performance plan will contain a performance measure that monitors development and testing of Bar Code Administration contingency plans.

Patient Satisfaction

VHA currently follows a longstanding approach to assessing VHA's quality of care along a number of dimensions – patient satisfaction, functional outcomes, veterans' personal health practices and clinical measures--each with separate measures, separate samples of veterans populations, and separate data analyses and reports. While each of these alone provide meaningful and well-reasoned evaluations of a given aspect of care, VHA realized that this approach presented end users with a significant challenge in converting the data across dimensions into actionable information. Starting in FY 2002, therefore, through the Performance Analysis Center for Excellence, VA will administer a new survey called the Survey of Health Expectations of Patients (SHEP) to collect self-reported information on:

- Satisfaction
- Functional outcomes (SF-12V)
- Healthy behaviors (equivalent to Prevention Index)

This provides a mechanism for VHA to collect and analyze data to provide more meaningful and useful information, especially at a cohort level. Upon receipt of the first data from this new process, analysis will be performed to identify opportunities for improvement and subsequent measures will be developed in the area of satisfaction.

The source of data for evaluating performance associated with the overall satisfaction of patients is a question on the Performance Analysis Center for Excellence (PACE) Inpatient and Ambulatory Care Satisfaction Surveys. The PACE satisfaction surveys are conducted using samples of inpatients and outpatients who are asked, among other things, to rate their care on a scale from "poor" to "excellent." The validity and reliability of the findings have been time tested and are based on rigorous survey methodologic principles. The numerator for this measure is those inpatients and outpatients who respond to the survey and who rate their care as "very good" or "excellent." The denominator is the total number of inpatients and outpatients in the sample who responded to the question on overall satisfaction.

Beginning in late 2002, the ambulatory care patient satisfaction survey will be conducted quarterly instead of semi-annually. The inpatient satisfaction survey will be conducted on a semi-annual basis. Results are published in hardcopy and electronic versions for internal VHA use by the Networks. Networks and medical centers will also conduct more frequent evaluations at the local level. These actions will increase facilities' ability to identify strategies to improve patient satisfaction.

The source of data for evaluating performance associated with the problems reported measure is a series of questions about patient education, visit coordination, and pharmacy services on the PACE inpatient and ambulatory care satisfaction surveys. The numerator is the average of the responses that indicate a problem for each item. The denominator is the total number of respondents to these questions in the surveys. A semi-annual report is available for each Network.

Balanced Scorecard

The sources of data for this performance goal is the same as those identified for the specific components comprising the measures— Chronic Disease Care Index II; Prevention Index II; inpatient and outpatient patient satisfaction; waiting times for primary care, specialty clinics; and wait times to see a provider. The cost element is obligations per unique patient in constant dollars.

All four components in the scorecard are of equal weight (each component is 25 percent of total) to achieve a scorecard of performance to goal. Because the cost factor uses 1997 as the base year for improvement, this element can result in a score greater than 25 percent. Consequently, the total score can be greater than 100 percent. We will review and update the methodology for this measure in advance of the next performance plan.

(For additional information about the medical care programs, refer to Medical Programs, Volume 2, Chapter 2.)

Provide Timely Access to Health Care

Strategic Goal: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

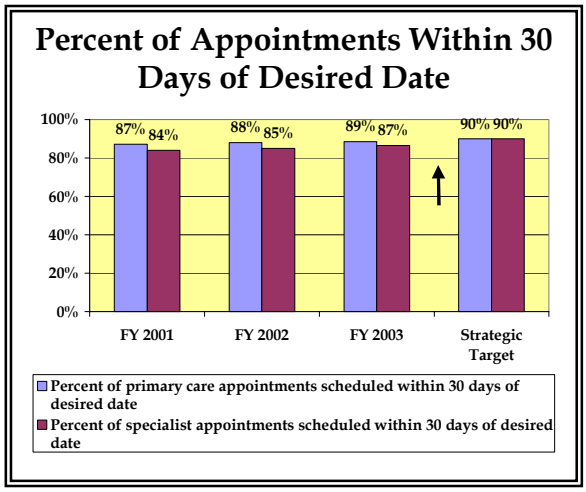
Secretary Priority: Provide access to primary care appointments and specialty care appointments within 30 days of desired date, and ensure patients are seen within 20 minutes of their scheduled appointment.

Performance Goals

1. Increase the percent of primary care appointments scheduled within 30 days of desired date to 89 percent.
2. Increase the percent of specialist appointments scheduled within 30 days of the desired date to 87 percent.
3. Increase the percent of patients who report being seen within 20 minutes of their scheduled appointments at VA health care facilities to 72 percent.

Current Situation Discussion

VA's strategy is to improve access to clinic appointments and timeliness of service. We continue efforts to develop ways to reduce waiting times for appointments in primary care and key specialty clinics in medical centers nationwide. The current measures of appointments seen within 30 days of desired date continues to show improvement. VA has a very strong commitment to decreasing appointment waiting times for the veterans we serve. Further analysis of sub-groups within these measures has resulted in additional monitoring in VHA for new patient and next available appointments.

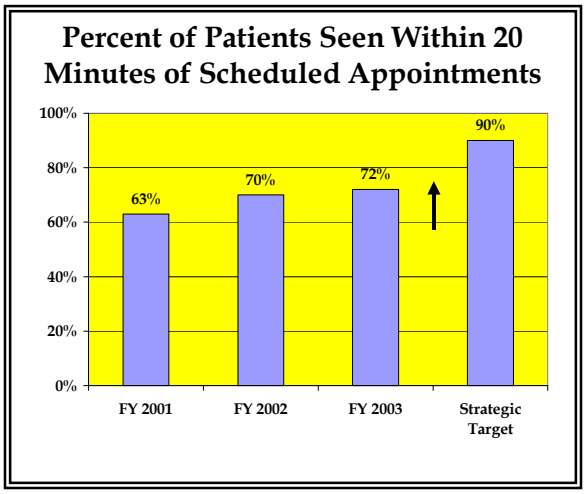


In addition, VHA has a large nationwide initiative to systematically improve clinic appointment processes.

The measure for the goal for timeliness of seeing a provider at the time of an appointment is derived from responses to the outpatient ambulatory survey question in which patients are asked, "How long after the time when your appointment was scheduled to begin did you wait to be seen?" Responses are tabulated to establish the percent of patients who reported waits of 20 minutes or less. Over the past 5 years, steady improvement in this area has been achieved.

Means and Strategies

The purpose of our access goals, which we refer to as the 30-30-20 strategy, is to define expectations for the length of time veterans wait to obtain appointments for non-urgent care, and how long they wait to see a provider for a scheduled appointment after arriving at a VA facility. VA's overall service and access goal is to provide personalized care when and where it is needed, in ways that are creative, innovative, and cost effective. Personalized care means continuity of care is provided and managed, across sites and types of care, through assignment of patients to a provider or team that knows the veteran, understands his or her needs, and coordinates and manages that care. Timely service ensures care is received when it is needed. Providing care in the manner most convenient to the veteran enables us to provide care where it is needed and wanted. The 30-30-20 goals are part of the performance agreements between the Network Directors and the Under Secretary for Health. This helps ensure a consolidated effort across the VA health care system to accomplish these goals.



The clinic waiting time performance measures are defined as the percentage of primary care (or specialty) clinic appointments scheduled within 30 days of desired date. This is the information that is reported externally. However, VHA collects and analyzes other data related to clinic waiting times for management information and decision support. In early 2000, VHA implemented software for measuring the average next available clinic appointment time experienced by patients needing an appointment. The software computes the clinic appointment waiting time by calculating the number of days between the date a next available appointment is requested and the date the appointment is made. This method of measurement is believed to be superior to previous methods, because it measures the actual experience of patients rather than projecting what the experience might be based on appointment availability. A revised version of this software was released January 31, 2001. This version allows a further measuring of appointment waiting times for new patients to primary care. In 2002, VA is exploring mechanisms to quantify the waiting times of newly enrolled patients.

The source of data for the 20-minute waiting time waiting measure is the semi-annual Performance Analysis Center for Excellence (PACE) National Ambulatory Care Satisfaction Survey. The numerator is the number of outpatients who report that they were seen within 20 minutes of their scheduled

appointments. The denominator is the universe of patients who respond to the following question: "How long after the time when your appointment was scheduled to begin did you wait to be seen?"

This is a measure of patients' self-reported responses to the question mentioned above. Therefore, a patient's perception of how long he or she must wait beyond the time of the scheduled appointment (rather than, for example, beyond the time of his or her arrival at the clinic) plays a large role in measuring performance in this area. Performance on this measure is currently reported semi-annually to Network Directors, but will be surveyed and reported on a quarterly basis beginning late in FY 2002.

External Factors

There are no external factors impacting on these performance measures.

Major Management Challenges

The General Accounting Office (GAO) has identified waiting times for appointments and treatments as a major management challenge. GAO states that VA cannot ensure that veterans receive timely care at VA medical facilities. GAO acknowledges that VA has taken steps to improve timeliness and quality of VA-provided care. In response to GAO concerns and those of veterans service organizations, VA has established measures for the time it takes for veterans to get appointments with VA providers and the time veterans spend waiting in provider's offices, and intends to continue monitoring the results closely. As part of its strategy to reduce waiting times, and meet service delivery targets, VA has entered into short-term contracts with consultants to help reduce the backlog of specialty appointments.

Data Source and Validation

VA's strategy is to improve access to clinic appointments and timeliness of service. We continue efforts to develop ways to reduce waiting times for appointments in primary care and key specialty clinics in medical centers nationwide. The current measure of the percent of primary (or specialty) appointments scheduled within 30 days of desired date continues to show improvement. VA has a very strong commitment to decreasing waiting time for appointments for the veterans we serve. Further analysis of sub-groups within these measures has resulted in additional monitoring in VHA for new patient and next available appointments. This same analysis identified a third sub-group where waiting time experience should be measured: new enrollees who have not yet made appointments. Standard enrollment and entry processes are currently under development to differentiate between those enrollees who want appointments from those that do not. A new survey will assist in the identification of the waiting time experience between enrollment and entry into the electronic scheduling system. The triangulation of all three experiences, i.e., waiting times for established patients, new patients once scheduled, and new

patients who have requested appointments, but are not yet scheduled, will allow for more effective and efficient management.

The measure for the goal for timeliness of seeing a provider at the time of an appointment is derived from responses to the ambulatory care satisfaction survey question in which patients are asked, "How long after the time when your appointment was scheduled to begin did you wait to be seen?" Responses are tabulated to establish the percent of patients who reported waits of 20 minutes or less. Over the past 5 years, steady improvement in this area has been achieved.

VA is developing new clinic wait time measures to quantify the wait times of new enrollees. VA is also developing a new survey to assess the experiences of new enrollees in requesting appointments. The data from the new measure, other VHA wait time measures, and the survey will provide more timely and relevant data for decision-making as it relates to the increase in numbers of new enrollees. VA is also recommending the development of standardized entry process for new enrollees. This process will assist in the automated collection of relevant wait time information at the time that the veteran enrolls in the system.

(For additional information about the medical care programs, refer to Medical Programs, Volume 2, Chapter 2.)

Refocus Medical Care on Higher-priority Veterans

Strategic Goal: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

Secretary Priority: Ensure access to high-quality health care for veterans with service-connected conditions and veterans who are poor.

Performance Goals

The full effect of focusing care on the highest priority veterans is not yet known. VHA is presently evaluating how this focus will impact on the number of veterans who receive care. Appropriate performance goals and measures will be developed when the impacts of focusing on disabled and lower-income veterans are more clearly established.

Current Situation Discussion

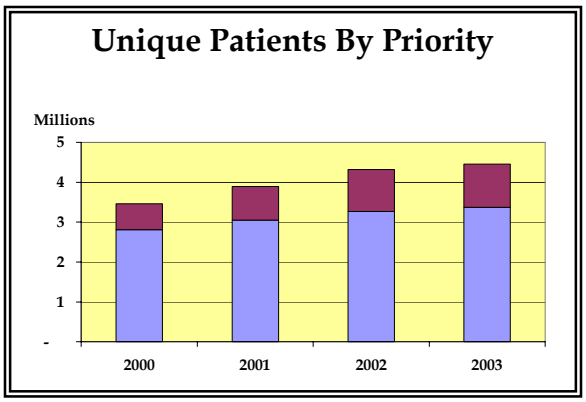
Public Law 104-262, the Veterans' Health Care Eligibility Report Act of 1996, required VA to enroll veterans for medical care in one of seven distinct priority levels. In general, veterans with service-connected disabilities and low incomes are in the highest priority levels for health care while most other veterans are in Priority 7, the lowest priority for care. The following describes how veterans are grouped into priorities:

- Priority 1: Veterans with service-connected conditions rated 50 percent or more disabling.
- Priority 2: Veterans with service-connected conditions rated 30 – 40 percent or more disabling.
- Priority 3: Veterans who are former POWs, who have service-connected conditions rated 10 to 20 percent disabling, who were discharged from active duty for a disability incurred or aggravated in the line of duty, or veterans awarded special eligibility under 38 U.S.C. 1511.
- Priority 4: Veterans who received aid and attendance or housebound benefits or who have been determined by VA to be catastrophically disabled.
- Priority 5: Non service-connected veterans and service-connected veterans rated zero percent disabled whose income are below established dollar thresholds.
- Priority 6: All other veterans who are not required to make co-payments for care, including World War I and Mexican Border veterans, veterans solely seeking care for disorders associated with exposure to a toxic substance, radiation or for disorders associated with service in the Persian Gulf, or compensable zero percent service-connected veterans.

- Priority 7: Non-service connected veterans and zero percent non-compensable service-connected veterans with income above the statutory threshold and who agree to pay specified co-payments related to health care provided to them.

Each year, VA's Secretary must determine what priority levels of veterans are eligible to receive care given the level of available resources provided by Congress. Since 1996, VA's Secretary has declared that all veterans are eligible to receive the full basic benefit package of health care services.

Because of the past and anticipated future increases in the number of Priority 7 veterans who are seeking VA health care, VA cannot continue to provide quality health care, especially to disabled and lower-income veterans, within the current direct appropriations. In order to meet the needs of service-connected and lower-income veterans, many of whom need care in a special population category, VA proposes that Priority 7 veterans cover a larger portion of their VA health care costs by assessing an annual deductible. This annual deductible, in addition to the recent increase in required pharmacy co-payments and decrease in outpatient co-payments, will allow VA's health care system to continue to deliver quality health care and to remain financially sound and sustainable for all veterans.



Means and Strategies

Priority 7 veterans, on average, use $1,890 worth of medical services from VA annually. Under the proposal to establish an annual deductible for Priority 7 veterans, these veterans will be assessed the annual deductible, with an annual ceiling of $1,500, for their inpatient and outpatient care at a rate of 45% of the reasonable charges. The current inpatient and outpatient co-payments would continue to be charged after the $1,500 deductible is paid.

This proposal is not designed to suppress demand. Rather, it is designed to provide Priority 7 veterans with medical and economic choices about their care. While it is expected that Priority 7 veterans will likely continue their enrollments in the VA health care system, some veterans may choose alternative care when faced with paying a deductible. Therefore, demand for health care for Priority 7 veterans should decrease. The reduction of overall net workload expenditures is estimated at $880 million with a revenue increase of $260 million in FY 2003. This reduction in workload expenditures and increase in revenue will help VA maximize appropriated resources to provide care for service-connected and

lower-income veterans (Priorities 1 – 6) and consequently better achieve VA's core mission.

Implementation of this change requires legislation to assess an annual deductible. It is essential that this be in law prior to the start of FY 2003 with sufficient lead-time for the preparation and approval of implementing legislation. All estimates of reduced expenditures and increased revenues assume that legislation will be passed and implementing regulations will be in effect as of October 1, 2002.

Crosscutting Activities

Achievement of this priority is not directly dependent on other agencies.

Major Management Challenges

There are no major management challenges identified that impact achievement of this priority.

Data Source and Validation

Data sources for any performance goals and measures are not yet identified because the goals and measures are still being developed.

(For additional information about the medical care programs, refer to Medical Programs, Volume 2, Chapter 2.)

Maintain High Level of Service to Insurance Policy Holders

Strategic Goal: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation

Secretary Priority: Maintain the high level of service to insurance policy holders and their beneficiaries.

Performance Goal

Timeliness of Insurance Disbursements

Maintain average processing time for insurance disbursements at 3.2 days.

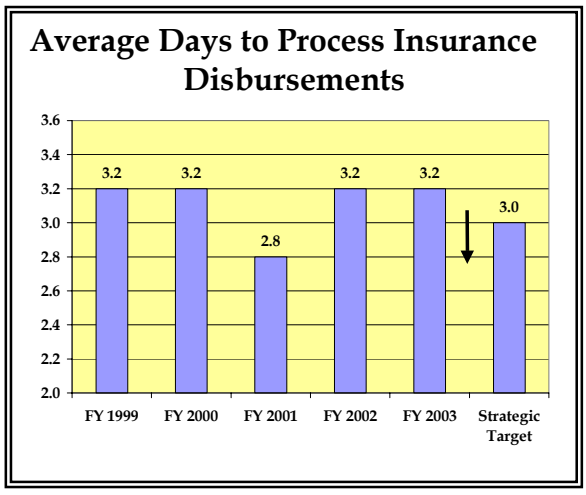
Enhance Insurance Programs

The recommendations of the program evaluation have been reviewed and an implementation plan developed. Performance goals will be developed after VA has approved the recommendations and the implementation plan.

Current Situation Discussion

Timeliness of Insurance Disbursements

Our strategic goal is to improve average processing time to 3 days, which is below the industry average of 3.1 processing days. Disbursements are considered the most important services provided by the insurance program to veterans and beneficiaries. The indicator for this measure is the weighted composite processing days for all three types of disbursements: death claims, loans, and cash surrenders. Weighted composite average processing days means that the volume of end products processed in each category is taken into account in the calculation of the average in order to make it more representative of the group.



We realized a better than expected improvement in average processing days in 2001, due to the installation of the first phase of the paperless processing system. When fully implemented, the paperless processing initiative will provide on-line electronic storage of insurance records and on-line access to those records by technicians. Over the last three years, we have mailed and processed over 1.5 million beneficiary designations of policyholders who have not updated their beneficiaries for many years. This large database of imaged beneficiary designations is allowing us to retire approximately 2.2 million insurance folders. Because of the

need for space in the Philadelphia Regional Office for a new Pension Processing Center, we have accelerated the schedule of the mass retirement of Insurance folders. We are expected to complete the folder retirement in early FY 2002, almost two years ahead of the original schedule.

Because we are retiring our insurance folders ahead of schedule and do not yet have the full imaging capabilities completed, we are using a hybrid system for disbursements consisting of imaged documents associated with temporary insurance folders. This temporary system actually provided faster disbursement processing than what we expected. When we move away from the hybrid system to the paperless processing system we will experience clerical and payroll savings. We expect disbursements to average 3.0 days once the paperless processing system is fully implemented in 2003 and insurance personnel get proficient with the new system.

Enhance Insurance Programs

Public Law 105-368 §303, Assessment of Effectiveness of Insurance and Survivor Benefits Programs for Survivors of Veterans with Service-Connected Disabilities, mandated an objective, third-party study of "Benefits for Survivors of Veterans with Service-Connected Disabilities." The purpose of the study was to determine the extent to which the VA Dependency and Indemnity Compensation (DIC) program and four VA-administered insurance programs -- Service Disabled Veterans Insurance (SDVI), Veterans' Mortgage Life Insurance (VMLI), Veterans' Group Life Insurance (VGLI), and Servicemembers' Group Life Insurance (SGLI) -- meet their statutory intent and the expectations of surviving family members, legislators, program officials, and other stakeholders. The study was expanded to a full program evaluation in order to fulfill the ongoing requirements of Public Law 103-62, the Government Performance and Results Act of 1993.

The study identified key factors in meeting program intent and stakeholder expectations:

- **Available and affordable insurance** - VA life insurance programs should be readily available and affordable to servicemembers and veterans, regardless of whether they are healthy or disabled.
- **Recognition of veteran's sacrifices** – Survivors should perceive that DIC program recognizes the sacrifices made by the servicemembers or veterans during their military service.
- **Adequate level of income support** - Survivors of veterans should have an adequate level of income support following the death of the veteran. The benefit level is the primary concern for DIC program beneficiaries.

The contractor provided suggested outcomes and generic suggestions on outcome measures. These are not dissimilar to the outcomes that the Veterans

Benefits Administration (VBA) had suggested prior to the study. VA will request input from stakeholder groups on suggested changes to outcomes. Outcomes and measures will then be finalized.

Table 1 below presents the highlights of study results that relate to the outcomes and goals suggested by the contractor. In summary, the study findings indicate that several of the expected outcomes are largely fulfilled but there are important exceptions as well, particularly with the comparison of VGLI and SDVI premiums to the private sector.

VA insurance is generally available in terms of comparison to the non-VA sector, regardless of the hazardous nature of certain work in the military or disability status. The availability and affordability of VA insurance for disabled veterans exceed availability and affordability in the private sector. The contractor did find that many SDVI survivors had very little life insurance. However, veterans of SDVI survivors had the opportunity to have enrolled in VGLI upon leaving the service. Hence, the life insurance was available, but the veteran had elected not to participate when they had the opportunity.

SGLI premium rates overall are 58 percent less than the median of private sector premiums, adjusting for age and gender differences between the military work force and the general civilian work force. VGLI premium rates compared unfavorably with a sample of private sector quotes for healthy individuals and in comparisons with military mutual aid associations' rates. Comparable rates for VGLI are considerably higher than the commercial quotes for non-smokers. An important contributing factor is that the private sector quotes do not cover unhealthy individuals while VGLI accepts all separatees regardless of health. SDVI premium rates are significantly higher than comparable rates for healthy individuals in the private sector.

Table 1. Program Outcomes, Goals, and Results

Program and Group Served	Outcomes	Goals	Results
SDVI Program: Veterans with service-connected disabilities	Veterans with service-connected disabilities are provided with the opportunity to obtain life insurance at standard premium rates without regard to their service-connected impairments for a reasonable time period following establishment of a service-connected disability.	For veterans with service-connected disabilities, parity with the options available to healthy individuals of similar ages to purchase reasonable amounts of life insurance in the individual market, within a reasonable time following the disability being established, and with comparable policy features.	SDVI participants had opportunity to obtain VGLI insurance, but many declined it. Half of SDVI beneficiaries receive only $15,000 or less in life insurance payments from all sources. The $10,000 basic coverage provided by SDVI is not adequate. SDVI premium rates are much higher than standard commercial rates for non-smokers.

Program and Group Served	Outcomes	Goals	Results
VMLI Program: Severely disabled veterans with service-connected disabilities who have received a grant for specially adapted housing.	Severely disabled veterans of any age and with service-connected disabilities can purchase mortgage life insurance in amounts consistent with current mortgage loans, and at standard premium rates.	Parity with the average non-disabled American's ability to purchase mortgage life insurance protection at any age in amounts consistent with current limits on mortgage loans and at competitive rates and with comparable policy features.	The $90,000 maximum mortgage protection life insurance under VMLI covers about 75% of the face value of mortgages of VMLI participants. VMLI premium rates are significantly lower than in the private sector for healthy individuals.
SGLI Program: Active Duty Servicemembers and Reservists	Insurance coverage is available to servicemembers and reservists and their family members at comparable costs that meets or exceeds the total life insurance benefit available to employees and their family members in large private sector organizations.	Availability of life insurance Is not affected by hazard. Meets or exceeds life insurance coverage levels for basic, supplemental, and dependent coverage made available by large private sector employers. Costs servicemembers no more than employee premiums available in large private sector organizations. Provides option to convert coverage upon termination.	Current $250,000 SGLI coverage is significantly higher than basic plans provided by private sector employers. Optional supplemental coverage is not available as it often is in the private sector. SGLI survivors in the study population received, on average, about $200,000 in life insurance benefits. Most private sector employers pay for basic coverage. SGLI premium paid by service-member compares favorably to premium costs for group life insurance (including basic and supplemental). Overall, median private sector premiums are 58% higher than SGLI premium. Conversion at termination for basic insurance is superior to conversion feature generally found in the private sector.
VGLI Program: Separated servicemembers and separated reservists	Separating servicemembers and reservists are guaranteed the opportunity to be covered by the same life insurance benefits as they had during active/ reserve service. VGLI costs per $1,000 of coverage, adjusted for health status, are consistent with what they would pay if purchasing equivalent coverage in the private sector.	Provide an option for automatic conversion of SGLI coverage at rates competitive with offerings in the private sector for healthy individuals.	Conversion of SGLI to VGLI is better than most private sector employers. VGLI survivors in the study population received, on average, about $100,000 in life insurance benefits. VGLI cost for the veteran compares unfavorably with a sample of private sector quotes for healthy individuals. Comparisons depend on specific age of individual, but in many cases VGLI rates are more than twice the commercial quotes.

The Program Evaluation of Benefits for Survivors of Veterans with Service-Connected Disabilities is complete and contains several recommendations that

are intended to enhance certain VA insurance programs. The recommendations are summarized below:

Servicemembers' Group Life Insurance (SGLI)

1. Offer a supplemental insurance option
2. Offer dependent's coverage option

Veterans' Group Life Insurance (VGLI)

1. Offer a supplemental insurance option
2. Publicize the conversion features of SGLI
3. Reduce VGLI premium rates to make them more comparable to commercial quotes

Service-Disabled Veterans Insurance (S-DVI)

1. Offer an automatic enrollment in S-DVI
2. Increase the basic coverage maximum to $50,000
3. Reduce S-DVI premium rates

Veterans' Mortgage Life Insurance (VMLI)

1. Remove the terminating at age 70 provision
2. Increase the current coverage maximum to between $150,000 and $200,000
3. Index maximum coverage to new loan origination amounts reported annually by the Federal Financial Institutions Examination Council (FFIEC).
4. Examine methods to increase participation by eligible disabled veterans

Means and Strategies

Timeliness of Insurance Disbursements

The insurance program has undertaken various actions to improve the timeliness of disbursements including special post office boxes, improvements in how we process returned mail and the elimination of data processing delays. We will install the full paperless processing system in 2003 throughout the insurance program. The imaging capabilities from that initiative will reduce the time required for processing disbursements and other services.

Enhance Insurance Programs

Three of the study's recommendations have already been implemented. Public Law 107-14 allows for SGLI dependent's coverage to become effective November 1, 2001. Effective July 9, 2001, VGLI premium rates were reduced,

which makes them more comparable to commercial quotes. Also, a plan was developed to increase VMLI participation by eligible disabled veterans.

An implementation plan was developed for the remaining recommendations which will provide: (1) an assessment of the strengths and weaknesses of the contractor's findings and recommendations (both program and technical), (2) identification of each study recommendation that VA recommends to be accepted and implemented, (3) an action plan for each accepted recommendation including major milestones and resource requirements, (4) recommended legislative proposals, (5) recommended changes to stated program objectives and outcomes, and (6) recommended changes to performance measures (outcome measures, customer satisfaction measures, process measures) and associated performance targets for the future. The implementation plan was completed and presented to the Deputy Secretary of VA in October 2001. The Deputy Secretary agreed with the Insurance Service's findings on all but two Insurance program recommendations. The Deputy Secretary requested additional information on the following two recommendations:

1. Increase basic S-DVI coverage maximum amount from $10,000 to $50,000.
2. Automatically provide S-DVI insurance coverage to any newly eligible veteran who is not enrolled in VGLI.

Crosscutting Activities:

Timeliness of Insurance Disbursements

Achievement of this goal is not directly dependent on other agencies.

Enhance Insurance Programs

Cooperation from the following stakeholders would possibly be required to implement some of the study's recommendations. These stakeholders include, veterans' service organizations, DoD, the individual service branches, Congress, the OMB, the SGLI Advisory Council, and Prudential Insurance Company of America (the parent company of the Office of Servicemembers' Group Life Insurance.)

Major Management Challenges:

There are no major management challenges that will affect achievement of insurance program goals.

Data Source and Validation

Timeliness of Insurance Disbursements

Processing time begins when the veteran's or beneficiary's application or request is received and ends when the Internal Controls Staff approves the disbursement. Average processing days are a weighted composite for all three types of disbursements, based on the number of end products and timeliness for

each category. The average processing days for death claims is multiplied by the number of death claims processed. The same calculation is done for loans and cash surrenders. The sum of these calculations is divided by the sum of death claims, loans and cash surrenders processed to arrive at the weighted average processing days for disbursements. Data on processing time is collected and stored through the SQC Program and the DOOR system. The Insurance Service is charged with periodically evaluating the SQC program to determine if it is being properly implemented. The composite weighted average processing days measure is calculated by the Insurance Service and is subject to periodic reviews.

Enhance Insurance Programs

Information on the study can be found in the "Program Evaluation of Benefits for Survivors of Veterans with Service-Connected Disabilities", Final Report, Volume I through Volume V, dated May 2001.

(For additional information about the insurance programs, refer to Benefits Programs, Volume 1, Chapter 3, and General Operating Expenses, Volume 4, Chapter 2F.)

Ensure Burial Needs are Met

Strategic Goal: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

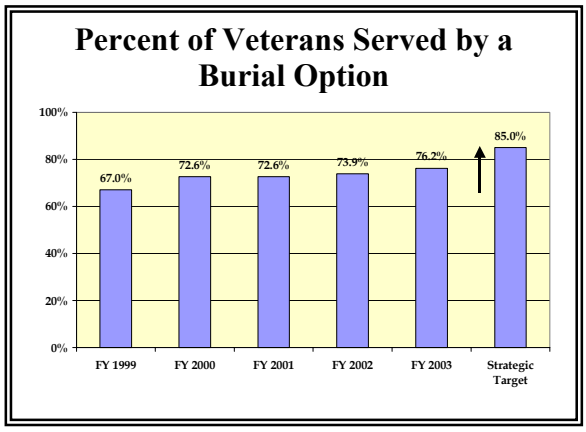
Secretary Priority: Ensure the burial needs of veterans and their eligible family members are met.

Performance Goals

1. Increase the percent of veterans served by a burial option in a national or state veterans cemetery within a reasonable distance (75 miles) of their residence to 76.2 percent by 2003.
2. Increase the percent of respondents who rate the quality of service provided by the national cemeteries as excellent to 96 percent by 2003.

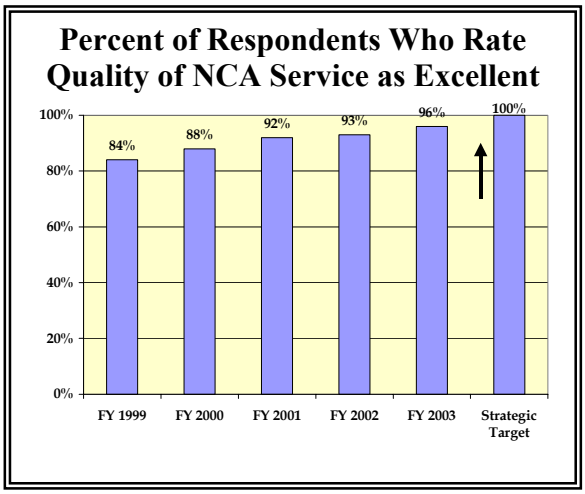
Current Situation Discussion

The mission of the National Cemetery Administration (NCA) is to "honor veterans with a final resting place and lasting memorials that commemorate their service to our Nation." As veteran deaths continue to increase throughout the planning time frame, NCA projects increases in the number of annual interments from 84,822 in 2001 to 90,500 in 2003, an increase of 7 percent. NCA data show that about 80 percent of persons interred in national cemeteries resided within 75 miles of the cemetery at time of death. Effective FY 2000, actual performance and the target levels of performance are based on the new VetPop2000 model developed by the VA Office of the Actuary.



As annual interments and total gravesites used increase, cemeteries deplete their inventory of space and are no longer able to accept casketed or cremated remains of first family members for interment. This reduces the burial options available to veterans. At the end of 2002, of the 120 existing national cemeteries, 61 will contain available, unassigned gravesites for the burial of both casketed and cremated remains; 24 will accept only cremated remains and remains of family members for interment in the same gravesite as a previously deceased family member; and 35 will perform only interments of family members in the same gravesite as a previously deceased family member. By the end of 2003, two national cemeteries will close. Often, when a national cemetery closes, veterans continue to be served by an open national or state veterans cemetery. For example, when Long Island National Cemetery closes in 2002, veterans will continue to be served by Calverton

National Cemetery. A state veterans cemetery recently built in Little Rock, Arkansas, will compensate for the effect of the closure of the Little Rock National Cemetery. By the year 2007, the Barrancas, Natchez, and Woodlawn National Cemeteries will exhaust their current supply of available, unassigned, full-casket gravesites. Efforts are underway to acquire additional land for full-casket interments at Barrancas and Natchez National Cemeteries. Additional land is not currently available to expand Woodlawn National Cemetery. Woodlawn National Cemetery will continue to accept first family member cremated remains and remains of family members for interment in the same gravesite as a previously deceased family member.



VA strives to provide high-quality, courteous, and responsive service in all of its contacts with veterans and their families and friends. These contacts include scheduling the committal service, arranging for and conducting interments, and providing information about the cemetery and the location of specific graves.

Means and Strategies

In order to achieve the performance goal of increasing the percent of veterans served by a burial option in a national or state veterans cemetery, VA will develop additional national cemeteries in unserved areas; expand existing national cemeteries to continue to provide service to meet projected demand, including the development of columbaria and the acquisition of additional land; and develop alternative burial options consistent with veterans' expectations.

Interment operations began at Fort Sill National Cemetery, near Oklahoma City, Oklahoma, in November 2001, providing service to over 165,000 veterans. A new national cemetery in the area of Atlanta, Georgia, will begin interment operations in 2003. NCA is also planning for the development of new national cemeteries to serve veterans in the areas of Detroit, Michigan; Miami, Florida; Pittsburgh, Pennsylvania; and Sacramento, California. When open, these five cemeteries will provide a burial option to nearly two million veterans who are not currently served by a national cemetery within a reasonable distance. These locations were identified in a May 2000 report to Congress as the six areas most in need of a new national cemetery, based on demographic studies.

VA will expand existing national cemeteries by completing phased development projects in order to make additional gravesites or columbaria

available for interments. Phased development in 10-year increments is a part of the routine operation of an open national cemetery. It is the practice of NCA to lay out and subdivide a cemetery by sections or areas so it may be developed sequentially as the need approaches. National cemeteries that will close due to depletion of grave space are identified to determine the feasibility of extending the service period of the cemetery by the acquisition of adjacent or contiguous land, or by the construction of columbaria.

The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, directed VA to contract for an independent demographic study to identify those areas of the country where veterans will not have reasonable access to a burial option in a national or state veterans cemetery, and the number of additional cemeteries required to meet veterans' burial needs through 2020. The contractor's report will be provided in the winter of 2002.

To achieve our performance goal to increase the percent of veterans served by a burial option, it is also necessary that state veterans cemeteries be established or expanded to complement VA's system of national cemeteries. NCA administers the State Cemetery Grants Program (SCGP), which provides grants to states of up to 100 percent of the cost of establishing, expanding, or improving state veterans cemeteries, including the acquisition of initial operating equipment. These cemeteries may be located by the states in areas where there are no plans for VA to operate and maintain a national cemetery. Forty-seven operating state veterans cemeteries have been established, expanded, or improved using the SCGP. By 2003, states will open 8 new state veterans cemeteries that will provide service to over 270,000 veterans not currently served by a burial option.

In meeting the burial needs of veterans and eligible family members, VA will continue to provide high quality, courteous, and responsive service. We will continue to obtain feedback from veterans, their families, and other cemetery visitors to ascertain how they perceive the quality of service provided. Using a customer satisfaction survey, NCA measures its success in delivering service with courtesy, compassion, and respect. We will also continue to conduct focus groups to collect data on stakeholder expectations and their perceptions related to the quality of service provided by national cemeteries. The information obtained is analyzed to ensure that NCA addresses those issues most important to its customers. This approach provides us with data from the customer's perspective, which are critical to developing our objectives and associated measures.

To increase awareness of benefits and services provided, NCA conducts outreach and education activities for the veteran community and the general public through the use of news releases, articles appearing in veterans service

organization publications, public service announcements, and presentations to schools and community organizations.

To further enhance access to information and improve service to veterans and their families, we will continue to install kiosk information centers at national and state veterans cemeteries to assist visitors in finding the exact gravesite locations of individuals buried there. In addition to providing the visitor with a cemetery map for use in locating the gravesite, the kiosk information center provides such general information as the cemetery's burial schedule, cemetery history, burial eligibility, and facts about the NCA. By 2003, VA plans to install 48 kiosks at national and state veterans cemeteries.

In order to accommodate and better serve its customers, VA developed three hub cemeteries to provide weekend scheduling of the interment in a national cemetery for a specific time in the ensuing week. Each hub cemetery provides this weekend service to families and funeral directors within its geographic area.

Veterans and their families have indicated that they need to know the interment schedule as soon as possible in order to finalize necessary arrangements. To meet this expectation, VA strives to schedule committal services at national cemeteries within two hours of the request. NCA is evaluating an instrument to collect data for timeliness of scheduling the committal service.

Crosscutting Activities

VA partners with the states to provide veterans and their eligible family members with burial options through the State Cemetery Grants Program (SCGP). NCA is also developing a planning model to encourage and help individual states in establishing state veterans cemeteries through the SCGP. Two components of the model, an "applicant information kit" and a "standard pre-design briefing," are now in use. Additional modules, to give applicants more information about costs, size and style of buildings, and other development guidelines, will also be included.

NCA and the State of Missouri co-sponsored the first national conference for directors of state veterans cemeteries. The conference, held in the fall of 2001, provided state cemetery directors with the latest information on best practices in operating federal veterans cemeteries and afforded directors the opportunity to share information and build networks that will result in better service to veterans and their families.

NCA works closely with components of DoD and veterans service organizations to provide military funeral honors at national cemeteries. While VA does not provide military funeral honors, national cemeteries facilitate the provision of funeral honors ceremonies and provide logistical support to funeral

honors teams. Veterans and their families have indicated that the provision of military funeral honors for the deceased veteran is important to them.

VA continues to work with funeral homes and veterans service organizations to find new ways to increase awareness of benefits and services. Funeral directors and members of veterans service organizations participate in regularly conducted focus groups to identify not only what information they need but also the best way to ensure that they receive it.

External Factors

Through the State Cemetery Grants Program, VA has established partnerships with states to provide veterans and their eligible family members with burial options. It is difficult to project future activity for this program because requests for grants are generated from individual states. A state must enact legislation to commit funding to a project that will serve a clearly defined population and require state funds for operations and maintenance in perpetuity.

Veterans and their families may experience feelings of dissatisfaction when their expectations concerning the committal service (including military funeral honors) are not met. Dissatisfaction with services provided by DoD (military funeral honors) or the funeral home can adversely affect the public's perceptions regarding the quality of service provided by the national cemeteries.

Major Management Challenges

There are no major management challenges that will affect achievement of these performance goals.

Data Sources and Validation

NCA determines the percent of veterans served by existing national and state veterans cemeteries within a reasonable distance of their residence by analyzing census data on the veteran population. Arlington National Cemetery, operated by the Department of the Army, and Andrew Johnson National Cemetery and Andersonville National Cemetery, operated by the Department of the Interior, are included in this analysis. Since FY 2000, actual performance and the target levels of performance have been based on the new VetPop2000 model developed by the Office of the Actuary. VetPop2000 is the authoritative VA estimate and projection of the number and characteristics of veterans. It is the first revision of official estimates and projections since 1993. The new VetPop2000 methodology resulted in significant changes in the nationwide estimate and projection of the demographic characteristics of the veteran population. These changes affected the separate county veteran populations from which NCA determines the percentage of veterans served. Projected openings of new national or state veterans cemeteries and changes in the service delivery status of existing cemeteries are also considered. (Multiple counts of the same veteran population are avoided in cases of service-area overlap.)

VA's Office of Inspector General performed an audit assessing the accuracy of data used to measure the percent of veterans served by the existence of a burial option (national or State cemetery) within a reasonable distance of place of residence. Audit results showed that NCA personnel generally made sound decisions and accurate calculations in determining the percent of veterans served by a burial option. Although inconsistencies in NCA's estimate of the percent of the veteran population served by a burial option were identified, they did not have a material impact and no formal recommendations were made. We have addressed these inconsistencies and the adjustments are included in this performance plan.

From FY 1996 to FY 2000, the source of data used to measure the quality of service provided by national cemeteries was the NCA Visitor Comment Card. For FY 2001 and subsequent years, NCA has developed a new customer satisfaction survey process. The survey is done via mail; the data are collected annually from family members and funeral directors who recently received services from a national cemetery. To ensure sensitivity to the grieving process, NCA allows a minimum of 3 months after an interment before including a respondent in the sample population. The measure for quality of service is the percent of respondents returning the survey who agree that the quality of service received from cemetery staff is excellent.

VA headquarters staff oversees the data collection process to measure the quality of service provided and compiles an annual report at the national level. Regional and cemetery level reports are provided for NCA management's use. The nationwide mail-out survey provides statistically valid performance information at the national and regional levels and at the cemetery level (for cemeteries having at least 400 interments per year).

(For additional information on the burial program, refer to General Operating Expenses, Volume 4, Chapter 4.)

Mark Graves in a Timely Manner

Strategic Goal: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

Secretary's Priority: Ensure graves in national cemeteries are marked in a timely manner.

Performance Goal

Mark (TBD) percent of graves in national cemeteries within 60 days of interment.

Current Situation Discussion

NCA provides headstones and markers for the graves of eligible persons in national, state, other public, and private cemeteries. The amount of time it takes to mark the grave after an interment is extremely important to veterans and their family members. The headstone or marker is a lasting memorial that serves as a focal point not only for present-day survivors but also for future generations. In addition, it brings a sense of closure to the grieving process to see the grave marked. Delivery of this benefit is not dependent on interment in a national cemetery. In 2001, NCA provided 304,296 headstones and markers for placement in national, state, or private cemeteries. The number of headstones and markers provided is expected to increase to 341,200 in the year 2003.

NCA will continue to provide Presidential Memorial Certificates (PMCs) to families of deceased veterans, recognizing the veteran's contribution and service to the Nation. A PMC conveys to the family of the veteran the gratitude of the Nation for the veteran's service. To convey this gratitude, it is essential that the certificate be accurately inscribed. NCA issued 327,561 Presidential Memorial Certificates in 2001, and expects this number to increase to 335,700 in the year 2003.

Means and Strategies

NCA has developed a new data collection instrument to measure the timeliness of marking graves at national cemeteries. NCA is currently collecting baseline data and validating the accuracy and integrity of the data collected. When this review is complete, performance targets will be established.

NCA has also begun to develop the mechanisms necessary to measure the timeliness of providing headstones or markers for the graves of veterans who are not buried in VA national cemeteries. NCA plans to assess data collection procedures to ensure that data collected to measure timeliness of delivery of headstones and markers are accurate, valid, and verifiable.

The Veterans Education and Benefits Expansion Act of 2001, Public Law 107-103, includes a provision that allows VA to furnish an appropriate marker for the

graves of eligible veterans buried in private cemeteries, whose deaths occur on or after December 27, 2001, regardless of whether the grave is already marked with a non-government marker. This authority expires on December 31, 2006. However, not later than February 1, 2006, VA shall report the rate of use of this benefit; an assessment as to the extent to which these markers are being delivered to cemeteries and placed on grave sites consistent with the provisions of law; and a recommendation for extension or repeal of the expiration date.

NCA will improve accuracy and operational processes in order to reduce the number of inaccurate or damaged headstones and markers delivered to the gravesite. Headstones and markers must be replaced when either the Government or the contractor makes errors in the inscription, or if the headstone or marker is damaged during delivery or installation. When headstones and markers must be replaced, it further delays the final portion of the interment process, the placing of the headstone or marker at the gravesite.

NCA will use, to the maximum extent possible, modern information technology to automate its operational processes. On-line ordering using NCA's Automated Monument Application System – Redesign (AMAS-R) and electronic transmission of headstone and marker orders to contractors are improvements that increase the efficiency of the headstone and marker ordering process.

NCA is also increasing its efficiency by encouraging other federal and state veterans cemeteries to place their orders for headstones and markers directly into NCA's AMAS-R monument ordering system. In 2001, 34 other federal and state veterans cemeteries ordered headstones and markers online.

Crosscutting Activities

NCA provides headstones and markers for national cemeteries administered by the Department of the Army, the Department of the Interior (DOI), and the American Battle Monuments Commission. Arlington National Cemetery, which is administered by the Department of the Army, and Andrew Johnson National Cemetery and Andersonville National Cemetery, which are administered by DOI, order headstones and markers directly through NCA's AMAS-R monument ordering system. NCA also contracts for all niche inscriptions at Arlington National Cemetery.

NCA also provides headstones and markers to state veterans cemeteries. State veterans cemeteries are encouraged to place their orders for headstones and markers directly into NCA's AMAS-R monument ordering system. NCA also extends its second inscription program to state veterans cemeteries. In this program, the second inscription is added *in situ* (i.e., at the gravesite) to the currently existing headstone following the death and interment of a subsequent family member. In order to participate, state cemeteries must use upright headstones and have the capability to submit requests electronically.

NCA administers the White House program for PMCs. A PMC is an engraved paper certificate, signed by the President, to honor the memory of honorably discharged deceased veterans. Eligible recipients include the deceased veteran's next of kin and loved ones.

External Factors

Headstones and markers are supplied by outside contractors throughout the United States, whose performance greatly affects the quality of service provided to veterans and their families. The timeliness of delivery of headstones and markers is dependent not only on the performance of the manufacturer but also on the performance of the contracted shipping agent. Extremes in weather, such as periods of excessive rain or extended periods of freezing temperatures, that impact on ground conditions can also cause delays in the installation of headstones and markers.

Major Management Challenges

There are no major management challenges that will affect achievement of this performance goal.

Data Source and Validation

Workload data are collected monthly through field station input to the Burial Operations Support System (BOSS) and AMAS-R. The number of headstones and markers ordered also includes markers ordered by the Logistics Division, such as the mass purchase of columbaria niche covers. The total number of PMCs issued, which includes those issued to correct inaccuracies, is reported monthly. Headquarters staff reviews the data for general conformance with previous report periods, and any irregularities are validated through contact with the reporting station.

When headstones or markers are lost, damaged, or incorrectly inscribed, it is important to determine both the cause and the party responsible for the expense of a replacement. NCA developed new codes for ordering replacement headstones or markers; use of these new codes produces reliable and accurate data on replacement actions and provides management with an effective tool for improving the overall business process.

(For additional information about NCA programs, refer to the General Operating Budget, Volume 4, Chapter 4B.)